



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HARRIS METHODIST FT WORTH  
3255 W PIONEER PKWY  
ARLINGTON TX 76013

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

LIBERTY INSURANCE CORP

#### **Carrier's Austin Representative Box**

Box Number 01

#### **MFDR Tracking Number**

M4-06-4028-01

#### **MFDR Date Received**

FEBRUARY 14, 2006

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as stated on the Table of Disputed Services:** "We review APC Medicare allowable for this admission. We respectfully ask that you review this claim at using 140% of Medicare calculation for fair and reasonable."

**Amount in Dispute:** \$5,664.66

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Payment was made per the TX FS at the trauma rate 85% of total billed charges after reduction of the CT scan to a fair and reasonable rate 100% of the TX FS Technical component for the CT scan. Total payment made per TX FS: \$4538.69 No PPO discount applied. Liberty Mutual does not believe that Harris Methodist Fort Worth Hospital is due any further reimbursement for services rendered to [injured employee] on date of service 5/11/05."

**Response Submitted by:** Liberty Mutual, 2875 Browns Bridge Rd., Gainesville, GA 30503

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2005 through May 13, 2005	Inpatient Services	\$5,664.66	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W10 (Z585) (M) – The charge for this procedure exceeds fair and reasonable.
  - W1 (Z695) (F) – The charges for this hospitalization have been reduced based on the fee schedule allowance.
  - W1 (Z560) (F) – The charge for this procedure exceeds the fee schedule or usual and customary allowance.
  - W1 (Z652) (F) – Recommendation of payment has been based on a procedure code which best describes services rendered.
  - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
  - Z989 – The amount paid previously was less than is due. The current recommended amount is the result of supplement payment.

## **Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 801.22. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 16, 2006, 27 *Texas Register* 4047, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective January 1, 2003, 27 *Texas Register* 12282, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor seeks 140% of Medicare reimbursement of billed charges based upon “We review APC Medicare allowable for this admission. We respectfully ask that you review this claim at using 140% of Medicare calculation for fair and reasonable.”
  - The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
  - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
  - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
  - The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	December 6, 2012 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**